Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

Advancing Understanding. Improving Lives.
Avancer la compréhension. Améliorer la vie.

Waypoint Centre for Mental Health Care
Consent to the Disclosure of Personal Health Information

I, ________________________________ , hereby authorize ________________________________
(print your full name/SDM name) (print the name of the health information custodian)

to disclose personal health information specified below of ________________________ , ______________
(print name of patient) (DOB: dd/mm/yyyy)

to ____
(print name of person/facility requesting information)

Address: ____
(print address of person/facility requesting information)

I consent to the following specific information to be disclosed/released:
☐ verbally ☐ copies of record of personal health information

____
____
____
____
____

I understand the purpose for disclosing this personal health information to the person or organization noted above. I understand that I can refuse to sign this consent form or later withdraw my consent by contacting a member of my treatment team.

________________________________ ________________________________
(signature of patient/SDM) (print name of witness)

________________________________ ________________________________
(if other than patient, state relationship to patient) (signature of witness)

________________________________ ☐ Verbal consent received
(Date: dd/mm/yyyy)

For an active patient/client, this consent will remain in effect for one year or until discharge, or at the conclusion of outpatient/community treatment, whichever occurs first.

WITHDRAWAL OF CONSENT

________________________________ ________________________________
(signature of patient/SDM) (print name of witness)

________________________________ ________________________________
(if other than patient, state relationship to patient) (signature of witness)

________________________________ ☐ Verbal consent received
(Date: dd/mm/yyyy)